

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

601

CERTIFICATE OF DEATH

Reg. Dist. No.

00596

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>New Market</i>		c. LENGTH OF STAY IN lb <i>3 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Willis</i> First <i>Edgar</i> Middle <i>Aldridge</i> Last		4. DATE OF DEATH <i>January 30</i> Month <i>1961</i> Day Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 10, 1867</i>
9. AGE (In years last birthday) <i>94</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Form</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William A. Aldridge</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Hoff Utz</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-18-0088A</i>	
INFORMANT <i>Mrs. Ernie Esworthy</i> Address <i>New Market, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis, Generalized</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 22</i> , 19 <i>60</i> , to <i>Jan 30</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>Dec 22</i> , 19 <i>60</i> , and that death occurred at <i>11:30 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.B. Culwell</i> M.D.		ADDRESS (Street, city or town, state) <i>mt. Airy, Md.</i> DATE SIGNED <i>Jan 30, 1961</i>	
PHYSICIAN'S NAME (Type) <i>W.B. Culwell</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb. 2, 1961</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Pleasant Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Monrovia Frederick Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. M. Waltz</i> ADDRESS <i>Winfield, Md.</i>		24a. REC'D BY REGISTRAR <i>FEB 2 '61</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

CHICAGO

CERTIFICATE OF REGISTRATION

100

*[Faint, mostly illegible text follows, appearing to be a form or certificate with various fields and lines.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
602 CERTIFICATE OF DEATH

00597

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN 1b <u>76 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick County Chronic Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> d. STREET ADDRESS <u>1209 West Patrick Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Roy</u>		First <u>Bitler</u> Last <u>Bitler</u>		4. DATE OF DEATH <u>JANUARY 2 1961</u>		Month <u>January</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 10 1984</u>	
9. AGE (In years lost birthday) <u>76</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick County</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Simon Bitler</u>		14. MOTHER'S MAIDEN NAME <u>DORA Appleby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>233-03-5917</u>		17. INFORMANT <u>MRS. MABEL F. BITLER - SAME AS 2D</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>260X</u> IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>260X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio Sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Unknown probably over 1 yr</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 8 1960</u> to <u>Jan 1 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 1 1961</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>H. F. Kline</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>H. F. KLINE, M.D.</u>				22d. ADDRESS <u>77 Market St. Frederick Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-5-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT OLIVET</u>		23d. LOCATION (City, town, or county) (State) <u>FREDERICK MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>M.R. ETCHEISON</u>				ADDRESS <u>106 E. CHURCH ST. - FRED MD</u>		25a. REC'D BY REGISTRAR <u>JAN 6 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH  
AND HUMAN SERVICES  
DIVISION OF VITAL RECORDS

03

NAME

THOMAS

DATE OF BIRTH 10-21-1901

PLACE OF BIRTH

DATE OF DEATH

10-21-1901

10-21-1901

10-21-1901

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

60598

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
c. LENGTH OF STAY IN 1b <b>Life</b>		d. STREET ADDRESS <b>1242 East Church Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>242 East Church Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LEROY</b> Middle <b>EDWARD</b> Last <b>BOONE, SR.</b>		4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 28, 1894</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City &amp; Foundry</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Boone</b>		14. MOTHER'S MAIDEN NAME <b>Cecelia (Last Name Unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-10-2654</b>	
17. INFORMANT <b>Mr. LeRoy E. Boone, Jr., Frederick, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>1/24/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 25, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>JAN 25 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Illegible]</p>		<p>AGE [Illegible]</p>	
<p>SEX [Illegible]</p>		<p>DATE OF BIRTH [Illegible]</p>	
<p>RESIDENCE [Illegible]</p>		<p>DATE OF DEATH [Illegible]</p>	
<p>CAUSE OF DEATH [Illegible]</p>		<p>MANNER OF DEATH [Illegible]</p>	
<p>PLACE OF DEATH [Illegible]</p>		<p>DATE OF EXAMINATION [Illegible]</p>	
<p>SIGNATURE OF EXAMINER [Illegible]</p>		<p>DATE [Illegible]</p>	

RECEIVED  
STATE DEPARTMENT OF HEALTH  
BOSTON  
JAN 10 1902



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/59

604 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00599

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Spenser</b> Middle <b>Brittain</b> Last 4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>1961</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route # 3 Frederick</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 31, 1891</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Sales Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sewickley, Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John B. Brittain</b>		14. MOTHER'S MAIDEN NAME <b>Julia B. Fedder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>167-03-4537</b>	
17. INFORMANT <b>Mrs. Cecilia D. Brittain</b>		Address <b>Rt. # 3 Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>4 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1957</b> to <b>Jan 4 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>Jan 4 1961</b> , and that death occurred at <b>4</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Henry V. Chase</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Henry V. Chase</b>		22d. ADDRESS <b>4 East Church Street Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-6-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert C. Valley</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 9 '61</b>	
ADDRESS <b>Frederick, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

Entscheidungsfindung

150-151

Dr. Emily V. Clark

125-1



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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAY 1961  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Kempton</b> 15X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Mem. Hosp.</b>		d. STREET ADDRESS <b>RFD #3, Mt. Airy</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BASIL</b> Middle <b>Walter</b> Last <b>Buxton</b>		4. DATE OF DEATH Month <b>January</b> Day <b>24</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 18, 1892</b>
9. AGE (In years lost birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Basil F. Buxton</b>		14. MOTHER'S MAIDEN NAME <b>Louisa H. Moxley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-34-4471</b>	
17. INFORMANT Address <b>Mrs Ella M. Buxton, Item 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X NEPHROSCLEROSIS - UREMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE ARTERIOSCLEROTIC</b> DUE TO (c) <b>CARDIOVASCULAR DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>60 days</b> <b>10 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>OBESEITY</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/18</b> <b>1961</b> to <b>1/24</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>1/24/1961</b> , and that death occurred at <b>11:38</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard C. Reynolds</b> M.D.		22b. DATE SIGNED <b>1/26/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard C. Reynolds</b>		22d. ADDRESS <b>9 E. Church St., Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 27, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Montgomery Meth.</b>		23d. LOCATION (City, town, or county) (State) <b>Clagettville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Moleworth</b> ADDRESS <b>Damascus, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 1 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

# CERTIFICATE OF DEATH

603

Proctor, Wm. H. 1890

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
606 CERTIFICATE OF DEATH 00601

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>11</b> Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>201 East Second Street</b>				d. STREET ADDRESS <b>201 East Second Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>REGINA</b> Middle <b>EISENHAUER</b> Last <b>BYERLY</b>				4. DATE OF DEATH Month <b>January</b> Day <b>20</b> , Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 4, 1873</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John Eisenhower</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Wehner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Charles Byerly-Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>10 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/1</b> 19 <b>60</b> to <b>1/20</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard C. Reynolds</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/21/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard C. Reynolds M.D.</b>				22d. ADDRESS <b>East Church Street, Frederick, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/23/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JAN 24 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

607

00602

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>DEMPSTER</b> Last <b>CAMPBELL</b>				4. DATE OF DEATH Month <b>January</b> Day <b>26</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9 July 1877</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Gananoque, Canada</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Dempster</b>				14. MOTHER'S MAIDEN NAME <b>Lucia Jackson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Bear Ridge Road, Roy C. Abbott, Pleasantville, N. Y.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of gall bladder</b> <b>155.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/29</b> , 19 <b>60</b> , to <b>1/26</b> , 19 <b>61</b> , that (I) (we) lost saw the deceased alive on <b>1/26</b> , 19 <b>61</b> , and that death occurred <b>3:30P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard C. Reynolds,</b>				M.D. ATTENDING PHYS. <b>xx</b> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <b>27 Jan 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard C. Reynolds, M. D.</b>				22d. ADDRESS <b>9 E. Church St., Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-29-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 30 61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

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• Robert •



608

CERTIFICATE OF DEATH

Reg. Dist. No.

00603

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MONROVIA</b>		c. LENGTH OF STAY IN 1b <b>60 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NETTIE</b> First <b>KINSEY</b> Middle <b>CASHOUR</b> Last		4. DATE OF DEATH <b>JAN 11 1961</b> Month <b>JAN</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 14 1875</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>MD</b>
13. FATHER'S NAME <b>WILLIAM R. KINSEY</b>		14. MOTHER'S MAIDEN NAME <b>CHRISTE RABBITT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>213-188868</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular disease</b> <b>422.01</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 52</b> to <b>Jan 1961</b> , that I last saw the deceased alive on <b>Nov 1960</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W.B. Culwell</b> M.D.		ADDRESS (Street, city or town, state) <b>900 So. Main</b> DATE SIGNED <b>1/11/61</b>	
PHYSICIAN'S NAME (Type) <b>W.B. Culwell</b>		<b>Mt. Airy, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JAN 14 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CENTRAL CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>NEW LONDON MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lucian K. Falconer</b> ADDRESS <b>New Market Md</b>		24a. REC'D BY REGISTRAR <b>JAN 19 61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>

CERTIFICATE OF DEATH

1900

100-1000

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Cause of death: \_\_\_\_\_

8. Signature of physician: \_\_\_\_\_

9. Signature of registrar: \_\_\_\_\_

10. Signature of informant: \_\_\_\_\_

11. Name of informant: \_\_\_\_\_

12. Address of informant: \_\_\_\_\_

13. Date of completion: \_\_\_\_\_

14. Signature of official: \_\_\_\_\_

15. Name of official: \_\_\_\_\_

16. Title of official: \_\_\_\_\_

17. Date of filing: \_\_\_\_\_

18. Name of hospital: \_\_\_\_\_

19. Name of physician: \_\_\_\_\_

20. Name of nurse: \_\_\_\_\_

21. Name of attendant: \_\_\_\_\_

22. Name of undertaker: \_\_\_\_\_

23. Name of funeral home: \_\_\_\_\_

24. Name of cemetery: \_\_\_\_\_

25. Name of burial place: \_\_\_\_\_

26. Name of interment: \_\_\_\_\_

27. Name of monument: \_\_\_\_\_

28. Name of grave: \_\_\_\_\_

29. Name of lot: \_\_\_\_\_

30. Name of block: \_\_\_\_\_

31. Name of street: \_\_\_\_\_

32. Name of city: \_\_\_\_\_

33. Name of county: \_\_\_\_\_

34. Name of state: \_\_\_\_\_

35. Name of country: \_\_\_\_\_

36. Name of continent: \_\_\_\_\_

37. Name of world: \_\_\_\_\_

38. Name of universe: \_\_\_\_\_

39. Name of everything: \_\_\_\_\_

40. Name of nothing: \_\_\_\_\_

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
609 CERTIFICATE OF DEATH

00604

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rocky Ridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rocky Ridge</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Own Home</b>				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Ersie</b> Middle <b>Floyd</b> Last <b>Clem</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>20</b> Year <b>19 61</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 6, 1886</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min. <b>74</b>		IF UNDER 24 HRS. Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min. <b>74</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm. U.G. Clem</b>				14. MOTHER'S MAIDEN NAME <b>Catherine E. Crouse</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>220-34-0496</b>		17. INFORMANT Address <b>Mrs. Edna Clem Rocky Ridge, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure Congestive heart disease</b> <b>434.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Hemorrhage</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>July 15 1960</b> to <b>Jan. 20 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan. 18 1961</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.							22b. DATE SIGNED
22a. SIGNATURE <b>James K. Gray</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>James K. Gray</b>				22d. ADDRESS <b>Thurmont, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-22-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Tabor Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rocky Ridge, Md. Fred. Co.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Crager</b>				ADDRESS <b>Thurmont, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 24 61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00605

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown, R.F.D.I.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown R.F.D.I.</b>	
c. LENGTH OF STAY IN 1b <b>8 months</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Joseph</b> Last <b>Colvin</b>		4. DATE OF DEATH Month <b>January</b> Day <b>II</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 20, 1900</b>
9. AGE (In years last birthday) <b>60 yrs.</b>		10. IF UNDER 1 YEAR Months <b>60</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ohio</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John William Colvin</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <b>Yes 1st &amp; 2</b>		16. SOCIAL SECURITY NO. <b>235-01-2407</b>	
17. INFORMANT <b>Mrs. John J. Colvin</b>		Address <b>Middletown R.F.D.I</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Dissecting Aneurysm of Aorta</b> 455A DUE TO (b) <b>Idiopathic Medial Cystic Degeneration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>hrs.</b> <b>?</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>		DATE SIGNED <b>January II, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 16, 1961</b>	
22c. NAME OF CEMETERY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 16 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO PRESS



611

## CERTIFICATE OF DEATH

Reg. Dist. No.

00606

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODSBORO</b>				c. LENGTH OF STAY IN 1b <b>YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MAIN ST</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELSIE</b> Middle <b>STULL</b> Last <b>CRAMER</b>				4. DATE OF DEATH Month <b>Jan</b> Day <b>23</b> Year <b>1961</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 6-1877</b>	9. AGE (in years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>RANDOLPH STULL</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE HULL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>		INFORMANT Address <b>MRS SHERMAN POWELL WOODSBORO</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute azotemia</b> <b>570.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Electrolyte imbalance</b> (c) <b>Intestinal obstruction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>48 hours</b> <b>about 4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 22</b> , 19 <b>61</b> , to <b>Jan. 23</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Jan. 22</b> , 19 <b>61</b> , and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ernest A. Dettbarn</b>		M.D.		ADDRESS (Street, city or town, state) <b>Wallsusville, Maryland</b>		DATE SIGNED <b>Jan. 25/61</b>	
PHYSICIAN'S NAME (Type) <b>ERNEST A. DETTBARN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/26/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT HOPE</b>		22d. LOCATION (City, town, or county) (State) <b>WOODSBORO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Powell &amp; Hargler Woodboro Md</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 27 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

612  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

66607

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>30 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>402 West South Street</b>		d. STREET ADDRESS <b>402 West South Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANDREW</b> Middle <b>J.</b> Last <b>CREAGER</b>		4. DATE OF DEATH Month <b>January</b> Day <b>1</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 Feb 1876</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Creager</b>		14. MOTHER'S MAIDEN NAME <b>Mary A. Musser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-10-4574</b>	
17. INFORMANT Address <b>Mrs. Mary E. Creager (Same as item #1)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422-1 Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular disease</b> DUE TO (c) <b>5 yrs +</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1</b> 19 <b>61</b> to <b>Jan 1</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Jan 1</b> 19 <b>61</b> , and that death occurred at <b>12</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>B. O. Thomas</b> M.D.		22b. DATE SIGNED <b>3 Jan 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>		22d. ADDRESS <b>228 N. Market St., Frederick, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-4-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 4 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CERTIFICATE OF DEATH

612

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS AND STATISTICS  
BOSTON, MASSACHUSETTS



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## 613

00608

1. PLACE OF DEATH o. COUNTY		Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Maryland		b. COUNTY		Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frederick		c. LENGTH OF STAY IN 1b		15 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Frederick Chronic Hospital		d. STREET ADDRESS		Montevue		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First CAROLINE		Middle CECILIA		Last CROUSE		4. DATE OF DEATH		Month January		Day 11, 1961	
5. SEX		Female		6. COLOR OR RACE		White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		March 16, 1883	
9. AGE (In years lost birthday)		77 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		House-work		10b. KIND OF BUSINESS OR INDUSTRY		At Home		11. BIRTHPLACE (State or foreign country)	
												12. CITIZEN OF WHAT COUNTRY?	
												USA	
13. FATHER'S NAME		William Frank Crouse		14. MOTHER'S MAIDEN NAME		Mary Elizabeth Neidhardt							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		No		16. SOCIAL SECURITY NO.		None		17. INFORMANT		106 East Second Street, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		491X		DUE TO		Chronic Pneumonia		INTERVAL BETWEEN ONSET AND DEATH		6 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Chronic myocarditis		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from		Mar 1958		to Jan 11, 1961		that (I) (we) last saw the deceased alive on Jan 10, 1961		and that death occurred at 3:15 AM		from the causes and on the date stated above.			
22a. SIGNATURE		H. F. Kline		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		1/12/61			
22c. PHYSICIAN'S NAME (Type)		H. F. Kline, M.D.		22d. ADDRESS		North Market Street, Frederick, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		23b. DATE THEREOF		1-14-61		23c. NAME OF CEMETERY OR CREMATORY		St. John's Cemetery		23d. LOCATION (City, town, or county) (State)	
												Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE		M. R. Etchison & Son, Frederick, Maryland		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
								DATE JAN 13 '61					

CERTIFICATE OF DEATH

(M)

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Signature of physician: [illegible]  
10. Signature of registrar: [illegible]

11. Name of informant: [illegible]  
12. Address of informant: [illegible]  
13. Signature of informant: [illegible]

14. Name of registrar: [illegible]  
15. Signature of registrar: [illegible]  
16. Date of registration: [illegible]  
17. Place of registration: [illegible]



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

614

CERTIFICATE OF DEATH

Reg. Dist. No. 00600

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>		c. LENGTH OF STAY IN 1b <b>5 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Valley View Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Henry Kieffer DeLauter</b>		4. DATE OF DEATH Month <b>1</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/23/1878</b>
9. AGE (In years lost birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>law</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Daniel T. DeLauter</b>		14. MOTHER'S MAIDEN NAME <b>Martha Mock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. ADDRESS <b>503 Fairview Ave., Mrs. Helen DeLauter, Frederick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 4</b> , 19 <b>60</b> , to <b>Jan 18</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Jan 17</b> , 19 <b>61</b> , and that death occurred at <b>7 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J Elmer Harp</b> M.D.		ADDRESS (Street, city or town, state) <b>Middletown, Md.</b> DATE SIGNED <b>Jan 1-19-60</b>	
PHYSICIAN'S NAME (Type) <b>Dr. J. Elmer Harp</b>		<b>Middletown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>1/21/1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 23 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
00610

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sabillasville</b>				c. LENGTH OF STAY IN 1b <b>21X-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Victor Cullen State Hospital</b>				d. STREET ADDRESS <b>415 George St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Leonard</b> Last <b>Eaton</b>				4. DATE OF DEATH Month <b>1</b> Day <b>7</b> Year <b>1961.</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-20-04</b>	9. AGE (In years lost birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer, contractors</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>contractors</b>		11. BIRTHPLACE (State or foreign country) <b>Mt. Briar, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US.</b>	
13. FATHER'S NAME <b>Otha J. Eaton</b>				14. MOTHER'S MAIDEN NAME <b>Martha Ellen Boyer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-05-7683</b>		17. INFORMANT <b>Hospital records</b> Address <b>Cullen, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced bilateral pulmonary tuberculosis</b> DUE TO (b) <b>002x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>002x</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-14-1960</b> to <b>1-7-1961</b> that (I) (we) last saw the deceased alive on <b>1-7-1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Michael G. Zavis</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1-7-61.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Michael G. Zavis</b>				22d. ADDRESS <b>Cullen, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/11/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Samples Manor Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b> <b>R. Frank Hoyer</b>				25a. REC'D BY REGISTRAR <b>AN 11 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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CERTIFICATE OF DEATH

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616  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mr. Clarence F. Fisher</b>		4. DATE OF DEATH <b>Jan 16 1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 16, 1901</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tire Capping</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own business</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cornelius Fisher</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Colliflower</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-22-8511</b>	
17. INFORMANT <b>Mary E. Fisher</b>		Address <b>Westminster, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 25, 1960</b> to <b>Jan 16, 1961</b> , that I last saw the deceased alive on <b>Jan 16, 1961</b> , and that death occurred at <b>Frederick, Md.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A.A. Pearre</b>		ADDRESS (Street, city or town, state) <b>Frederick, Md.</b> DATE SIGNED <b>1/16/61</b>	
PHYSICIAN'S NAME (Type) <b>A.A. Pearre</b>		<b>4 E. Church St. Frederick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-19-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. L. Cresger</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 19 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kenna</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

617

## CERTIFICATE OF DEATH

Reg. Dist. No.

00612

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Exzile Marcella Virginia Fisher</b>		4. DATE OF DEATH Month <b>1</b> Day <b>-</b> Year <b>5 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1-1893</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (State or foreign country) <b>Howard Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Fisher</b>		14. MOTHER'S MAIDEN NAME <b>Exzile Lyles</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Damascus, Md.</b>		18. ADDRESS <b>Reymor Fisher-9190 Main Street</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Graves disease</b> <b>252.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thyrototoxic heart disease</b> DUE TO (c) <b>years</b> <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> to <b>1-5-</b> <b>1961</b> that I last saw the deceased alive on <b>1-4-</b> <b>1961</b> and that death occurred at <b>1:30</b> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1-7-61</b>			
ACTUAL SIGNATURE <b>Rex Martin</b> M.D.		DATE SIGNED <b>1-7-61</b>	
PHYSICIAN'S NAME (Type) <b>Rex Martin</b>		<b>2-20 Market St. Frederick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-9-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Simpson</b>	22d. LOCATION (City, town, or county) (State) <b>Poplar Springs-Carroll Co. Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Hicks</b> <b>111</b> <b>Frederick, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 11 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kious</b>	

CERTIFICATE OF DEATH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

618  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00613

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X FREDERICK THURMONT</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSP</u>		d. STREET ADDRESS <u>1 Rte #4</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY GIRL FRITZ</u>		4. DATE OF DEATH Month Day Year <u>January 27 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 26, 1961</u>
9. AGE (In years last birthday) <u>18</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>RONALD CLEVELAND FRITZ</u>		14. MOTHER'S MAIDEN NAME <u>PATRICIA ANN MISNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>776X</u> IMMEDIATE CAUSE (a) <u>Immaturity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>26 Jan 1961</u> to <u>27 Jan 1961</u> , that (I) (we) last saw the deceased alive on <u>26 Jan 1961</u> , and that death occurred at <u>4:30 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R L Guest</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. R. L. Guest</u>		22d. ADDRESS <u>6432nd St. Frederick</u>	
22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 28. 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Thurmont Fredk. Co. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>		24b. ADDRESS <u>Thurmont, MD</u>	
25a. REC'D BY REGISTRAR <u>JAN 30 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Anas</u>	

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100-443887-100

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 615 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00614

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY HEALTH EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Walkersville</b>		c. LENGTH OF STAY IN 1b <b>seconds</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>stricken while driving on Road.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>NEWTON</b> Last <b>GRIMES</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>4th</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2.1912</b>
9. AGE (In years last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager-Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Airport</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John B. Grimes</b>		14. MOTHER'S MAIDEN NAME <b>Florence M. Stull</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-10-2525</b>	
17. INFORMANT <b>Mabel F. Grimes</b>		Address <b>Thurmont.R.D.I.Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Thrombosis</b> (c) <b>Atherosclerotic Heart Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>12 hrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Heart Disease</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. Thomas.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>Jan. 5. 1961</b>	
22a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		22b. DATE THEREOF <b>Jan. 7. 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Creagerstown Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Creagerstown Fred k. Co. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Md</b>	
24a. REC'D BY REGISTRAR <b>JAN 9 61</b>		24b. REGISTRAR'S SIGNATURE <b>Raymond E. Creager</b>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE NO. 12

STATION

MARYLAND

NAME OF DECEASED

Henry J. Henry Jr.

AGE 30

SEX M

RESIDENCE 1111 N. E. Street

DATE OF DEATH 10-1-1918

CAUSE OF DEATH

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40-1-1918



620

## CERTIFICATE OF DEATH

Reg. Dist. No.

00615

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>417 Klincharts Alley</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Elizabeth</b> Last <b>Gross</b>		4. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1-1893</b>
9. AGE (In years lost birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>7</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Clara Palm</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-24-9957</b>	
17. INFORMANT <b>Marshall Palm</b>		Address <b>-9 W. 6th St. Fred. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Intestinal Tract</b> DUE TO <b>153-9</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metastasis to liver</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 16, 1960</b> , to <b>Jan 2, 1961</b> , that I last saw the deceased alive on <b>Jan 2, 1961</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Bldg. Frederick, Md.</b> DATE SIGNED <b>Jan 4, 1961</b>			
ACTUAL SIGNATURE <b>B.O. Thomas Sr.</b>		M.D. <b>Jan 4, 1961</b>	
PHYSICIAN'S NAME (Type) <b>B.O. Thomas Sr.</b>		<b>Professional Bldg. Frederick, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-5-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fairview</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Hicks 111</b>		ADDRESS <b>Frederick, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The purpose of this document is to provide information regarding the activities of the [redacted] organization in the [redacted] area. This information was obtained from a confidential source who has provided reliable information in the past.

2. The [redacted] organization is a [redacted] group that is active in the [redacted] area. It is believed that the organization is engaged in [redacted] activities and is a threat to the [redacted] area.

3. The [redacted] organization has been active in the [redacted] area for a number of years. It is believed that the organization is engaged in [redacted] activities and is a threat to the [redacted] area.

4. The [redacted] organization has been active in the [redacted] area for a number of years. It is believed that the organization is engaged in [redacted] activities and is a threat to the [redacted] area.

5. The [redacted] organization has been active in the [redacted] area for a number of years. It is believed that the organization is engaged in [redacted] activities and is a threat to the [redacted] area.

6. The [redacted] organization has been active in the [redacted] area for a number of years. It is believed that the organization is engaged in [redacted] activities and is a threat to the [redacted] area.

7. The [redacted] organization has been active in the [redacted] area for a number of years. It is believed that the organization is engaged in [redacted] activities and is a threat to the [redacted] area.

8. The [redacted] organization has been active in the [redacted] area for a number of years. It is believed that the organization is engaged in [redacted] activities and is a threat to the [redacted] area.

9. The [redacted] organization has been active in the [redacted] area for a number of years. It is believed that the organization is engaged in [redacted] activities and is a threat to the [redacted] area.

10. The [redacted] organization has been active in the [redacted] area for a number of years. It is believed that the organization is engaged in [redacted] activities and is a threat to the [redacted] area.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

621

00616

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>47 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EFFIE</b> Middle <b>LARUE</b> Last <b>HARDING</b>		4. DATE OF DEATH Month <b>January</b> Day <b>17</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 Sept 1903</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Unionville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Vernon C. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Hartsock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-22-7601</b>	
17. INFORMANT <b>Thomas E. Harding (Same as item #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 15, 1945</b> to <b>Jan 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan 17, 1961</b> , and that death occurred at <b>11:55P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>B. O. Thomas</b>		22b. DATE SIGNED <b>19 Jan 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>		22d. ADDRESS <b>228 N. Market St., Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-20-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rocky Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Near Woodsboro, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 24 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

CONFIDENTIAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

622

CERTIFICATE OF DEATH

Reg. Dist. No.

00617

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>304 W. South St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Alta F. House</b>		4. DATE OF DEATH <b>1 25 19 61</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/12/1884</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. UNDER 1 YEAR <b>Months</b>	11. UNDER 24 HRS. <b>Days</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Daniel Rohrback</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Gaver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Dorthy Hines, Frederick, Md.</b>		Address <b>304 W. South St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro vascular accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9/24</b> , 19 <b>59</b> , to <b>1/20</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>1/20</b> , 19 <b>61</b> , and that death occurred at <b>6:55 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard C. Reynolds, M.D.</b>		ADDRESS (Street, city or town, state) <b>9 E. Church St.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Dr. Richard C. Reynolds</b>		<b>Frederick, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>1/28/1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Locust Valley Ch. of God. Cem., Frederick Co., Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>gladhill Company, Middletown, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 30 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knease</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00618

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Cumberland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bridgeton</b>			
c. LENGTH OF STAY IN 1b <b>2 Yrs.</b>				d. STREET ADDRESS <b>46 Railroad Avenue</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>213 East Fifth Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Rebecca Jaquett</b>				4. DATE OF DEATH Month Day Year <b>January 14 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12 Aug 1888</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housekeeper</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Charles H. Jaquett, Bridgeton, N. J.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease with</b> <b>4200</b> DUE TO <b>coronary thrombosis (sudden)</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> (b) <b>Arteriosclerosis generalized</b> lying cause last. (c) <b>9 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-20-1960</b> to <b>1-14-1961</b> , that (I) (we) last saw the deceased alive on <b>1-14-1961</b> , and that death occurred at <b>1 A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Rex R. Martin</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Rex R. Martin MD</b>				22d. ADDRESS <b>220 N. Market St, Frederick, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>1-18-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dividing Creek Meth. Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Dividing Creek, New Jersey</b>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 19 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

1. Name of deceased	2. Sex	3. Age	4. Date of birth
5. Date of death	6. Place of death	7. Cause of death	8. Signature of physician
9. Signature of registrar	10. Date of registration	11. Place of registration	12. Signature of registrar

*Butchered at the kitchen with  
a sharp knife (2011-1-14)  
1/14/11*

1-14-11 1-14-11

1-14-11  
*W. B. M. M.*

## CERTIFICATE OF DEATH

Reg. Dist. No.

00619

624

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK-MEMORIAL-HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ADDIE BURGER JOHNSTON</b>				4. DATE OF DEATH Month Day Year <b>JANUARY 13 1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 6 - 1889</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>GEORGE BURGER</b>				14. MOTHER'S MAIDEN NAME <b>LYDIA STIFF</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NO</b>		INFORMANT <b>MRS RICHARD COMSTOCK WOODSBORO MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery sclerosis with acute coronary thrombosis</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis + recurrent thromboses</b> DUE TO <b>years</b> (c) <b>Generalized arteriosclerosis</b> DUE TO <b>years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>60</b> , to <b>Jan 13</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Jan 13</b> , 19 <b>61</b> , and that death occurred at <b>home</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Rex R Martin</b>		M.D. <b>220 N. MARKET</b>		ADDRESS (Street, city or town, state) <b>FREDERICK, MD.</b>		DATE SIGNED <b>1-13-61</b>	
PHYSICIAN'S NAME (Type) <b>Rex R Martin</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>JAN 14 - 61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN</b>		22d. LOCATION (City, town, or county) (State) <b>BLADENSBURG MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron E. Hartzler</b>		ADDRESS <b>New Windsor, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 17 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneiss</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

George Henry ...  
Cause of death ...  
Signed ...

1-13-13  
220 N. ...  
Fordwick, Ill.

1913  
John ...  
L. E. ...

1 *35*  
 M  
 069  
 625  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 00620

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>				c. LENGTH OF STAY IN 1b <i>9 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp.</i>				d. STREET ADDRESS <i>15X-2</i>			
3. NAME OF DECEASED (Type or print) <i>John A Jones</i>				4. DATE OF DEATH <i>Jan 4 1961</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/10/1878</i>	9. AGE (In years last birthday) <i>82</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired farm, owner</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>John A. Jones</i>				14. MOTHER'S MAIDEN NAME <i>Rose Darby</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>2-20-14-4342</i>		17. INFORMANT <i>Mrs John A Jones, Poolesville, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>A50.0</i> DUE TO <i>Mesenteric Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis, generalized, severe</i> DUE TO <i>10 yrs +</i> (c)						INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 26 1960</i> to <i>Jan 4 1961</i> , that (I) (we) last saw the deceased alive on <i>Jan 4 1961</i> , and that death occurred at <i>5:10 A.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Henry V. Chase</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Jan 4, 1961</i>			
22c. PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>		22d. ADDRESS <i>415 Church St Frederick Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12/6/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Monocacy</i>	23d. LOCATION (City, town, or county) (State) <i>Beallsville Md</i>				
24. FUNERAL DIRECTOR'S SIGNATURE <i>William B. Hilton</i>			ADDRESS <i>Barnesville Md</i>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>William B. Hilton</i>	
			DATE <i>JAN 9 '61</i>				





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00621

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. LENGTH OF STAY IN Tn <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mountville Road - Route 4</u>		d. STREET ADDRESS <u>Mountville Road - Route 4</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 30-1873</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Jones</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Myers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hilda V. Weedon-310W. South St. Fred. Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor</u> <u>237X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B.O. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B.O. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>January 21-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-24-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sunnyside</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Hicks 111 Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>JAN 24 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 627 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00622

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick R.F.D.3</b>		c. LENGTH OF STAY IN 1b <b>8 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>Frederick R.F.D.3</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna Mary Kauffman</b>		4. DATE OF DEATH Month Day Year <b>January 14 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1913</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Frederick Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Samuel T. Toms</b>		14. MOTHER'S MAIDEN NAME <b>Mary C. Kauffman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-14-5902</b>	
17. INFORMANT <b>Raymond Kauffman, Frederick R.F.D.3</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Artero-sclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hr.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>January 14, 1961</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/16/1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glade</b>		22d. LOCATION (City, town, or county) (State) <b>Walkersville MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. C. Barton</b>		ADDRESS <b>Walkersville MD</b>	
24a. REC'D BY REGISTRAR <b>DATE JAN 19 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Samuel S. Thomas</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00623

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Thurmont Rt.-1</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Klipp</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>10-</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-28-1877</b>	
9. AGE (In years lost birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Paul Klipp</b>				14. MOTHER'S MAIDEN NAME <b>Mary Korrell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mrs. John H. Klipp-Thurmont- Md.- Route 1</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thromboses</b> DUE TO <b>332x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arterio-sclerosis</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma prostate.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 10</b> 19 <b>61</b> to <b>Jan 10</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Jan 9</b> 19 <b>61</b> , and that death occurred at <b>7:20 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>B.O. Thomas Jr.</b>				22b. DATE SIGNED <b>Jan. 11-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. B.O. Thomas-Jr.</b>				22d. ADDRESS <b>Professional Bldg.-Frederick-Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 14-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick- Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Dwyer</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 16 '61</b>			
ADDRESS <b>Frederick- Md.</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

## 550

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**TABLE 1**

1990

5:02:5

• *Submitted by: [Name]*

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151 - 107-10-000



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00624

629

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Frederick</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Edgewood Church Road (Rt. # 7)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Catherine</b> Last <b>Knill</b>		4. DATE OF DEATH Month <b>January</b> Day <b>24</b> , Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 22, 1914</b>
9. AGE (In years last birthday) <b>46</b> yrs.		10. IF UNDER 1 YEAR Months <b>46</b> Days <b>46</b> Hours <b>46</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employed at Frederick Tailoring Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Frederick, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Besst</b>		14. MOTHER'S MAIDEN NAME <b>Iva Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-1011</b>	
17. INFORMANT Address <b>Mr. John H. Knill Route # 7 Frederick, Md.</b>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-21</b> , 19 <b>61</b> , to <b>1-23</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>1-23</b> , 19 <b>61</b> , and that death occurred at <b>11:45</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. U. G. Bourne, Jr.</b>		22b. DATE SIGNED <b>1-28-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. U. G. Bourne, Jr.</b>		22d. ADDRESS <b>30 W. All Saints Street Frederick, Md.</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-27-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Driley, Jr.</b>		25a. REC'D BY REGISTRAR <b>JAN 30 '61</b>	
ADDRESS <b>Frederick, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Hanna</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

630  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00625

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>			d. STREET ADDRESS <b>Near Doubs</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>REBECCA</b> Last <b>LAMM</b>			4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>1961</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 Dec 1904</b>		9. AGE (In years last birthday) <b>56</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>William Jenkins</b>			14. MOTHER'S MAIDEN NAME <b>Mary Keller</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Millard E. Lamm (Same as item #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic heart disease</b> DUE TO (c) <b>General arteriosclerosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr</b> <b>unknown</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>11/10</b> 19 <b>60</b> to <b>1/30</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>1/30</b> 19 <b>61</b> , and that death occurred at <b>9:30A</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>Kenneth C. Henson</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2 Feb 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Kenneth C. Henson, M. D.</b>		22d. ADDRESS <b>Middletown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-3-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Jefferson, Maryland</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			25a. REC'D BY REGISTRAR DATE <b>FEB 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hense</b>

CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

631

## CERTIFICATE OF DEATH

Reg. Dist. No.

00626

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>15 E. Church Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MILLARD T. LEASE</b>		4. DATE OF DEATH Month Day Year <b>January 28 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 12, 1914</b>
9. AGE (In years last birthday) yrs. <b>46</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward Lease</b>		14. MOTHER'S MAIDEN NAME <b>Grace Tregonning</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-10-5003</b>	
17. INFORMANT <b>Mrs. Cynthia Lease, Same as 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive upper intestinal hemorrhage</b> DUE TO (b) <b>Rupture of esophageal mucosa</b> DUE TO (c) <b>(Mallory-Weiss Syndrome)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis, active</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 26, 1961</b> , to <b>Jan 28, 1961</b> , that I last saw the deceased alive on <b>Jan 28, 1961</b> , and that death occurred at <b>6 A M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Henry V Chase</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>4 E Church St 1/28/61</b>	
PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>		<b>Frederick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 31, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Marvin Chapel Cemetery</b>		22d. LOCATION (City, town, or County) (State) <b>Frederick Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz, Winfield, Maryland</b>		24a. REC'D BY REGISTRAR <b>JAN 30 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALABAMA STATE DEPARTMENT OF HEALTH-BIRMINGHAM, 18



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TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00627

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>40 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>402 Carroll Parkway</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Strine</b> Last <b>Lenhart</b>		4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14-1897</b>
9. AGE (In years lost birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>63</b> Days <b>63</b>	IF UNDER 24 HRS. Hours <b>63</b> Min. <b>63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Gregg J. Strine</b>	
14. MOTHER'S MAIDEN NAME <b>Katherine Kauffman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>214-14-6588</b>		17. INFORMANT <b>Mrs. Dwight Roy-303 Trail Ave.-Frederick-Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dissecting aneurysm of thoracic Aorta</b> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>15 hours</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 9 1961</b> to <b>Jan 10 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan 9 1961</b> , and that death occurred at <b>3:30 A.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. L.R. Schoolman</b>		22b. DATE SIGNED <b>Jan. 11-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. L.R. Schoolman</b>		22d. ADDRESS <b>810 Toll House Ave.-Frederick-Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 13-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Woodsboro- Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Dailly</b>		25a. REC'D BY REGISTRAR <b>Jan 16 '61</b>	
ADDRESS <b>Frederick- Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

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JAN 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535  
MEMORANDUM  
TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, mostly mirrored bleed-through from the reverse side of the page.]

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CERTIFICATE OF DEATH

Reg. Dist. No.

00628

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Knoxville</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>-</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ezra Roy Magaha</b> First Middle Last		4. DATE OF DEATH <b>1</b> Month <b>15</b> Day <b>1961</b> Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-16-1886</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>	
13. BIRTHPLACE (State or foreign country) <b>Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>Burr F. Magaha</b>		16. MOTHER'S MAIDEN NAME <b>Sophornia Arnold</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		18. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mrs. Virginia Magaha, Knoxville, Md.</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute congestive heart failure</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>chronic Myocarditis</b> DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/26/60</b> , 19 <b>60</b> to <b>1/15</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>1/10</b> , 19 <b>61</b> , and that death occurred at <b>5 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. B. Carpenter</b>		ADDRESS (Street, city or town, state) <b>Brunswick, Md.</b> DATE SIGNED <b>1/17/61</b>	
PHYSICIAN'S NAME (Type) <b>W. B. CARPENTER</b>		<b>BRUNSWICK, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-18-1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brothorn</b>		22d. LOCATION (City, town, or county) (State) <b>Burkittsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Hu Feito</b> ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR <b>JAN 23 61</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Frank</b>	

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

PLACE: \_\_\_\_\_

CAUSE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 634 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00629

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near New Market</b>			c. LENGTH OF STAY IN 1b <b>5 Months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near New Market</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Arline</b> Last <b>Moals</b>				4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-7- 1954</b>	
9. AGE (In years last birthday) <b>6</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School girl</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Howard Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Moals Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Warfield</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>George Moals Jr. New Market R.F.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>916.0 Third Degree Burnes</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Traped in burning house</b>					
20c. TIME OF INJURY Month, Day, Year <b>5-30 I/5/61 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) M.D. (State) <b>Nr. New Market, Frederick</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Naturol causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B.O. Thomas</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>I/5/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-8-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olive Hills</b>		22d. LOCATION (City, town, or county) (State) <b>New Windsor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Luther H. Haight</b>				ADDRESS <b>Lylesville, Md</b>		24b. REGISTRAR'S SIGNATURE <b>Cynthia S. Hauer</b>	
				24a. REC'D BY REGISTRAR <b>JAN 9 '61</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX M		3. AGE 35	
4. DATE OF DEATH MAY 6 1968		5. TIME OF DEATH 11:00 AM		6. PLACE OF DEATH FEDERAL BUREAU OF INVESTIGATION WASHINGTON, D.C.	
7. OCCUPATION ATTORNEY		8. CAUSE OF DEATH HEART DISEASE		9. MANNER OF DEATH SUICIDE	
10. SIGNATURE OF MEDICAL EXAMINER [Signature]		11. SIGNATURE OF DECEASED [Signature]		12. SIGNATURE OF WITNESS [Signature]	
13. SIGNATURE OF CORONER [Signature]		14. SIGNATURE OF JURY [Signature]		15. SIGNATURE OF JUDGE [Signature]	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
635 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00650

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Market R.D.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Near New Market R.F.D.</b>	
c. LENGTH OF STAY IN TB <b>5 Months</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nancy Faline</b> Middle <b>Moals</b> Last <b>Moals</b>		4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>12-19 1950</b>	9. AGE (in years last birthday) <b>10</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School girl</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Howard Co</b>
13. FATHER'S NAME <b>George Moals Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Warfield</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>George Moals Jr.</b>		Address <b>New Market R.F.D.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Third Degree Burnes</b> DUE TO 916-0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Traped in burning house</b>	
20c. TIME OF INJURY Month, Day, Year <b>5-30 1/5/61</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Nr. New Market</b>		(County) <b>Frederick</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>I/5/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-8-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		22d. LOCATION (City, town, or county) (State) <b>New Market Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Luther H. Haight</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 9 '61</b>	
ADDRESS <b>Sykesville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Haight</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BRANCH 18  
635 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY		19. SIGNATURE OF JURY		20. SIGNATURE OF JURY	
21. SIGNATURE OF JURY		22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY		25. SIGNATURE OF JURY	
26. SIGNATURE OF JURY		27. SIGNATURE OF JURY		28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY		34. SIGNATURE OF JURY		35. SIGNATURE OF JURY	
36. SIGNATURE OF JURY		37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY		40. SIGNATURE OF JURY	
41. SIGNATURE OF JURY		42. SIGNATURE OF JURY		43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY		49. SIGNATURE OF JURY		50. SIGNATURE OF JURY	
51. SIGNATURE OF JURY		52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY		55. SIGNATURE OF JURY	
56. SIGNATURE OF JURY		57. SIGNATURE OF JURY		58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY		64. SIGNATURE OF JURY		65. SIGNATURE OF JURY	
66. SIGNATURE OF JURY		67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY		70. SIGNATURE OF JURY	
71. SIGNATURE OF JURY		72. SIGNATURE OF JURY		73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY		79. SIGNATURE OF JURY		80. SIGNATURE OF JURY	
81. SIGNATURE OF JURY		82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY		85. SIGNATURE OF JURY	
86. SIGNATURE OF JURY		87. SIGNATURE OF JURY		88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY		94. SIGNATURE OF JURY		95. SIGNATURE OF JURY	
96. SIGNATURE OF JURY		97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY		100. SIGNATURE OF JURY	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

636

1  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00631

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THOMAS</u> First <u>Boy</u> Middle <u>E.</u> Last <u>O'Brien</u>		4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 25, 1961</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>6</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Russell O'Brien Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Dolores Crummitt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Russell E. O'Brien Jr.</u>		Address <u>R.D. #6 Frederick, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> DUE TO <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>25 Jan 1961</u> to <u>26 Jan 1961</u> , that (I) <u>two</u> last saw the deceased alive on <u>26 Jan 1961</u> , and that death occurred at <u>9:20 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R. L. Guest</u>		22b. DATE SIGNED <u>27 JAN 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. R. L. Guest</u>		22d. ADDRESS <u>6 W 3rd St. Frederick Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-30-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Frederick Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison and Son</u>		25a. REC'D BY REGISTRAR <u>JAN 30 '61</u>	
ADDRESS <u>Frederick, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>	

CERTIFICATE OF BIRTH

Blank form with faint horizontal lines and a vertical margin line on the right. Two punch holes are visible on the right edge.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
637  
CERTIFICATE OF DEATH

00632

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>60 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Chronic Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>Phelps</b> Last <b>Oden</b>				4. DATE OF DEATH Month <b>1</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 18 - 1877</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>3</b> Hours <b>15</b> Min.		IF UNDER 24 HRS. Months <b>8</b> Days <b>3</b> Hours <b>15</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Richard Phelps</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Karr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>Records Frederick Chronic Hospital</b>				Address <b>Frederick Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c) <b>Arterio Sclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>June 1955</b> to <b>Dec 24, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec 24, 1960</b> , and that death occurred at <b>8:15 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>H. Kline</b>				22b. DATE SIGNED <b>Jan 3, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. H. F. KLINE</b>				22d. ADDRESS <b>7 N. MARKET ST. Frederick Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>1-4-1961</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>				23d. LOCATION (City, town, or county) (State) <b>Frederick - Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. [Signature]</b>				25a. REC'D BY REGISTRAR <b>Frederick, Maryland</b>			
25b. REGISTRAR'S SIGNATURE <b>Clara E. [Signature]</b>				DATE <b>JAN 6 '61</b>			

CENTRAL OF DEATH

Maryland

Revised-March 1911

None Records, Frederick Chronic Hospital

No

Frederick, Maryland

Dr. H. F. Kline, 7 N. Market St. Frederick, Md.

April 1-4-1911 Mt. Olivet Cemetery, Frederick, Md.

Frederick, Maryland



## CERTIFICATE OF DEATH

Reg. Dist. No.

00633

638

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>				c. LENGTH OF STAY IN 1b <b>X</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ijamsville P.O.</b>				d. STREET ADDRESS <b>Ijamsville</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marvin Kent Onley</b>				4. DATE OF DEATH Month Day Year <b>January 4 1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 26-60</b>	9. AGE (In years lost birthday) <b>*** yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Booker T. Ford</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Onley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----		INFORMANT Address <b>Dorothy Thompson - Ijamsville P.O. Fred. Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>764.0</b> IMMEDIATE CAUSE (a) <b>Diphtheria</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3 Jan</b> , 19 <b>61</b> , to _____, 19____, that I last saw the deceased alive on <b>3 Jan</b> , 19 <b>61</b> , and that death occurred at <b>5:34</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>R L Guest</b> M.D. _____ ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>R.L. Guest</b> <b>6 West 3rd Street Frederick, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-5-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ebernezer</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>C.E. Hicks 111 Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>JAN 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2069253XV5

CERTIFICATE OF DEATH

253

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Frederick

YES ☐ NO ☐

19 67

HOURS	MIN.
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12. CITIZEN OF WHAT COUNTRY?

U.S.A.

Anna America Sencil

Mrs. May Rice, Burkittsville, Md

2 days

2 mon.

5 yrs.

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☐

(Stote)

DATE SIGNED \_\_\_\_\_

1-27-61

Brunswick, Md.

(State)

24b. REGISTRAR'S SIGNATURE

Getting 2 Kraus

CERTIFICATE OF DEATH

CHIEF OF POLICE

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

640 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00635

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ijamsville-Rural RD#1</b> c. LENGTH OF STAY IN 1b <b>10 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Hyattstown</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ijamsville-Rural RD#1</b> d. STREET ADDRESS <b>Near Hyattstown</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MAURICE</b> Middle <b>C.</b> Last <b>RICKETTS</b>				4. DATE OF DEATH Month <b>January</b> Day <b>30</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 Sept 1881</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>	IF UNDER 24 HRS. Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Day Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-30-0339</b>		17. INFORMANT <b>Mrs. Mary E. Johnson (Same as item #1)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot of Skull and Brain</b> DUE TO (b) <b>976X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b>976X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Gun placed in mouth and discharged</b>					
20c. TIME OF INJURY Month, Day, Year <b>3</b> Hour <b>3:30</b> <b>1- 30 1961</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Nr. Hyattstown-Frederick-Md.</b>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-2-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Beallsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. L. Burdette, Hyattstown, Maryland</b>				24a. REC'D BY REGISTRAR <b>FEB 1 1961</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

MEDICAL CERTIFICATION

2

pp

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES J. JONES		35		M		W		C	
RESIDENCE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
1000 N. E. Street		10-1-1918		10:00 AM		Home		Heart Disease	
OCCUPATION		EDUCATION		MARRIAGE		SINGLE		MARRIED	
Clerk		High School		Yes		10-1-1918		10-1-1918	
PREVIOUS ILLNESS		TREATMENT		DIET		SMOKING		ALCOHOL	
None		None		None		None		None	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CAUSE	
J. J. Jones		10-1-1918		10:00 AM		Home		Heart Disease	
SIGNATURE OF WITNESS		DATE		TIME		PLACE		CAUSE	
J. J. Jones		10-1-1918		10:00 AM		Home		Heart Disease	



FOR STATE  
HEALTH DEPT.

(M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

641

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00636

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 26 ENROUTE TO</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FREDERICK MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Israel</u> Middle <u>Porter</u> Last <u>Rinehart</u>				4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 15, 1891</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>night watchman M R R</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Winfield Rinehart</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Deville</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>705-05-4334</u>			
17. INFORMANT <u>MARGARET O. RINEHART</u>				Address <u>Union Bridge MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN CAUSE AND DEATH <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>B. C. Thomas</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>B. C. Thomas, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>January 12, 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN 15-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT VIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>UNION BRIDGE, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Q. D. Hutchins</u>				24a. REC'D BY REGISTRAR <u>JAN 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u>	

MEDICAL CERTIFICATION



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

3642

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

66637

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#4</b>		c. LENGTH OF STAY IN 1b <b>Since Oct-60</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Near Feagaville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ADA</b> Middle <b>ELLEN</b> Last <b>SCHELL</b>		4. DATE OF DEATH Month <b>January</b> Day <b>31</b> , Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 Nov 1884</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>3</b> Hours <b>30</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel Haifleigh</b>		14. MOTHER'S MAIDEN NAME <b>Elmira Hartman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-24-7741</b>	
17. INFORMANT <b>Mrs. Mary B. Fogle (Same as item #1)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma ovary</b> DUE TO <b>(with carcinomatous perforated structures)</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. 175.0 (b) <b>3 months</b> (c) <b>3 months</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1 1960</b> to <b>Jan 30 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan 30 1961</b> , and that death occurred at <b>12:30A</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Bernard O. Thomas, Jr.</b>		22b. DATE SIGNED <b>1 Feb 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Bernard O. Thomas, Jr.</b>		22d. ADDRESS <b>228 N. Market St., Frederick, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-2-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 3 1961</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

100

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 643 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00638**

**FOR STATE HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#2</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Vienna</b> <span style="float: right;"><b>83X-3</b></span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Frederick-U. S. Highway Route 15-S</b>				d. STREET ADDRESS <b>615 Tazewell Road</b>			
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>WILLIAM</b> Last <b>SCHULER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 2, 1924</b>		9. AGE (In years last birthday) <b>36</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (If engaged in work done during most of working life, even if retired) <b>Assistant Director of Mines for United Mine Workers</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ralph Schuler</b>				14. MOTHER'S MAIDEN NAME <b>May C Queke</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWII</b>		16. SOCIAL SECURITY NO. <b>193-16-9269</b>		17. INFORMANT <b>Mrs. Louis W. Schuler-Same as Item #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broken Neck</b> <b>816X</b> DUE TO <b>Crushed Chest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Crushed Chest</b> DUE TO (c) <b>Crushed Chest</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Headon Collision with another Car</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Headon Collision with another Car</b>					
20c. TIME OF INJURY Month, Day, Year <b>4:35</b> <b>1-2-61</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>State Highway</b>		20f. (City or town) (County) (State) <b>Frederick-Rural, Frederick, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>1-3-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wilkes-Barre, Pa.</b>		22d. LOCATION (City, town, or county) (State) <b>Wilkes-Barre, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>JAN 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00639

644

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Knoxville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Valley View Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>May</b> Last <b>Shafer</b>				4. DATE OF DEATH Month <b>January</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-14-1885</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Burkittsville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rural Mail Carrier Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Burkittsville, Maryland</b>			
13. FATHER'S NAME <b>Thomas K. Shafer</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth May Karn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-30-9824</b>		17. INFORMANT Address <b>Mr. A. T. Shafer Rt. # 5 Frederick, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>150X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Breast - Metastasis to Lung + liver.</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>18 mo</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 28 1960</b> to <b>Jan 15 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan 13 1961</b> , and that death occurred at <b>5:20 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>J. Elmer Harp</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-16-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. J. Elmer Harp</b>				22d. ADDRESS <b>M.D. Middletown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-18-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Burkittsville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Walcott</b>				ADDRESS <b>Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 17 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-23-53

CERTIFICATE OF DEATH

814



State of Tennessee  
County of Davidson  
I, the undersigned, a duly qualified and authorized officer of the State of Tennessee, do hereby certify that the within and foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears from the records of the State of Tennessee, and that the same is a true and correct copy of the original record of the death of the person named therein, as the same appears from the records of the State of Tennessee.

Witness my hand and the seal of the State of Tennessee, this 23rd day of January, 1953.

JOHN W. HARRIS, Secretary of State

1-23-53

State of Tennessee  
County of Davidson  
I, the undersigned, a duly qualified and authorized officer of the State of Tennessee, do hereby certify that the within and foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears from the records of the State of Tennessee, and that the same is a true and correct copy of the original record of the death of the person named therein, as the same appears from the records of the State of Tennessee.

Witness my hand and the seal of the State of Tennessee, this 23rd day of January, 1953.

JOHN W. HARRIS, Secretary of State

1-23-53

645

CERTIFICATE OF DEATH

Reg. Dist. No.

00640

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK CITY</b>				c. LENGTH OF STAY IN 1b <b>3 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>129 E. SIXTH ST,</b>				d. STREET ADDRESS <b>RURAL WALKERSVILLE</b>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>ALBERT</b> Last <b>SHELTON</b>				4. DATE OF DEATH Month <b>1</b> Day <b>5</b> Year <b>19 61</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/1875</b>	
9. AGE (In years lost birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARETAKER CEMETERY</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>FORMAN</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>				13. FATHER'S NAME <b>GEORGE W. SHELTON</b>			
14. MOTHER'S MAIDEN NAME <b>SALLY KELLER</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>217-18-8418</b>				17. INFORMANT <b>Alvie E. Shelton 129 E 6th Frederick md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO <b>286.5</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malnutrition</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/1</b> , 19 <b>61</b> , to <b>1/5</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>1/3</b> , 19 <b>61</b> , and that death occurred at <b>2 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>228 N. Market St. Frederick, Maryland</b> DATE SIGNED <b>1/6/61</b>							
ACTUAL SIGNATURE <b>James B. Thomas</b>		M.D. <b>James B. Thomas</b>		ADDRESS (Street, city or town, state) <b>228 N. Market St. Frederick, Maryland</b>		DATE SIGNED <b>1/6/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/8/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glade</b>		22d. LOCATION (City, town, or county) (State) <b>Walkersville Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GC Boston</b>				ADDRESS <b>WALKERSVILLE MD</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 10 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. File No.

PLACE OF DEATH HOME		DEATH REPORTED BY PHYSICIAN	
DATE OF DEATH JAN 10 1918		TIME OF DEATH 10:00 AM	
PLACE OF BIRTH BALTIMORE, MD		AGE 34	
SEX FEMALE		COLOR WHITE	
MARRIED YES		OCCUPATION HOUSEWIFE	
CAUSE OF DEATH INFLUENZA		MANNER OF DEATH NATURAL	
PLACE OF DEATH HOME		DEATH REPORTED BY PHYSICIAN	
DATE OF DEATH JAN 10 1918		TIME OF DEATH 10:00 AM	
PLACE OF BIRTH BALTIMORE, MD		AGE 34	
SEX FEMALE		COLOR WHITE	
MARRIED YES		OCCUPATION HOUSEWIFE	
CAUSE OF DEATH INFLUENZA		MANNER OF DEATH NATURAL	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF IT IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER.

646

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>17 "A" Street</b>				d. STREET ADDRESS <b>17 "A" Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Albert</b> Last <b>Sigafoose</b>				4. DATE OF DEATH Month <b>1</b> Day <b>7</b> Year <b>61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-1-1867</b>	
9. AGE (In years lost birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired General Track Foreman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R. R. Co.</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Henry Sigafoose</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Watkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs. Esther Stewart, Brunswick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (b) <b>Serious</b> DUE TO (c) <b>ly</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12-1-1960</b> to <b>1-7-1961</b> , that I last saw the deceased alive on <b>1-2-1961</b> , and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. E. TRUITT</b> M.D.				ADDRESS (Street, city or town, state) <b>Brunswick, Md.</b> DATE SIGNED <b>1-9-61</b>			
PHYSICIAN'S NAME (Type) <b>C. E. TRUITT</b>				<b>BRUNSWICK MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-10-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>		22d. LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. W. Fute</b>				ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 10 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
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STATE OF NEW YORK  
DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

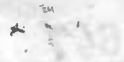
00642

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#7</b>				c. LENGTH OF STAY IN 1b <b>Since 12-30-60</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Buckeystown</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick County Chronic Hospital</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>LEE</b> Last <b>SIMMONS</b>				4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>30 Sept 1860</b>	
9. AGE (In years last birthday) <b>100</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James S. Simmons</b>				14. MOTHER'S MAIDEN NAME <b>Ann Eliza Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>2629 St. Paul St., Mrs. Mary S. Shipley, Baltimore 18, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho Pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1945</b> to <b>Jan 4</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Jan 4</b> , 19 <b>61</b> , and that death occurred at <b>8:20 P.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>B. O. Thomas</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6 Jan 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>		22d. ADDRESS <b>228 N. Market St., Frederick, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-7-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

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BT



1. General Information

2. Description of the Product

3. Manufacturing Process

4. Quality Control

5. Inventory Management

6. Cost Analysis

7. Production Schedule

8. Safety and Health

9. Environmental Impact

10. Conclusion

11. Appendix

12. References

13. Notes

14. Signatures

15. Date

16. Initials

17. Remarks

18. Comments

19. Suggestions

20. Other

21. Total

22. Average

23. Standard Deviation

24. Coefficient of Variation

25. Correlation Coefficient

26. Regression Equation

27. Residuals

28. Summary

29. Final Remarks

30. End of Report

### MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55



649

## CERTIFICATE OF DEATH

Reg. Dist. No.

00644

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Middletown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E.</u> Last <u>STEVENS</u>		4. DATE OF DEATH Month <u>1</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/14/1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Alexander</u>		14. MOTHER'S MAIDEN NAME <u>Cora Brandenburg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Edward N. Stevens, Middletown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of I leum 2X</u> <u>152.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with widespread metastases</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Diabetes mellitus</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>29</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 29</u> , 19 <u>60</u> , to <u>Jan 27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan 27</u> , 19 <u>61</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas E. Stone</u> M.D.		ADDRESS (Street, city or town, state) <u>4 West 3rd St</u> DATE SIGNED <u>1-28-61</u>	
PHYSICIAN'S NAME (Type) <u>Thomas E. Stone</u>		<u>Frederick, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>1/30/1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Middletown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 31 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

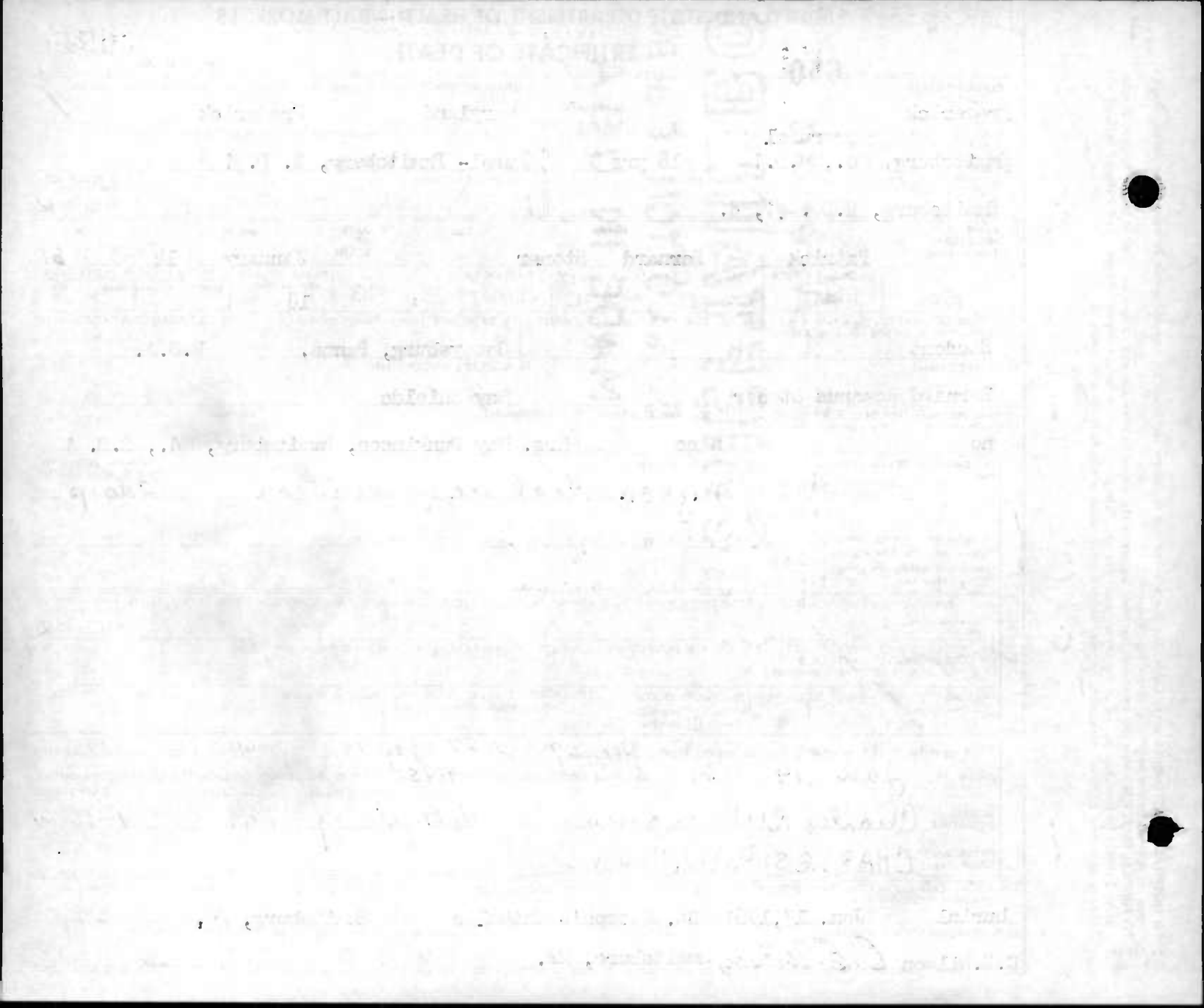
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







Item 18 Film 279 1-27-61 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Items 5,8,7,0 Film 279 1-24-61 et <b>CERTIFICATE OF DEATH</b> 650 Reg. Dist. No. 00645											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg, Md., R.D. 1</b> c. LENGTH OF STAY IN lb <b>18 yrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Emmitsburg, R.D. #1 Md.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Emmitsburg, R. D. 1</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Patrick</b> Middle <b>Bernard</b> Last <b>Stoner</b>				<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>14</b> Year <b>19 61</b>				<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>January 13, 1943</b> <b>9. AGE</b> (In years lost birthday) <b>18</b> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Student</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Gettysburg, Penna.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>13. FATHER'S NAME</b> <b>Bernard Romanus Stoner</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>May Shields</b>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> <b>16. SOCIAL SECURITY NO.</b> <b>none</b> <b>INFORMANT</b> <b>Mrs. May Dunkinson, Emmitsburg, Md., R.D. 1</b> <b>Address</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial degeneration</b> <b>081X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Polomyelitis - 10-22-52</b> DUE TO (c) <b>Pneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)											
<b>21. I certify</b> that I attended the deceased from <b>Dec 27</b> , 19 <b>57</b> , to <b>Jan 14</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Jan 14</b> , 19 <b>61</b> , and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <b>Gettysburg, Pa.</b> <b>DATE SIGNED</b> <b>1-16-61</b> <b>ACTUAL SIGNATURE</b> <b>Charles R. Williams</b> M.D. <b>PHYSICIAN'S NAME (Type)</b> <b>CHARLES R. WILLIAMS</b>											
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>burial</b> <b>22b. DATE THEREOF</b> <b>Jan. 17, 1961</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Joseph's Catholic</b> <b>ADDRESS</b> <b>Emmitsburg, Md.</b> <b>22d. LOCATION</b> (City, town, or county) (State)				<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>C. E. Wilson</b> <b>ADDRESS</b> <b>Emmitsburg, Md.</b> <b>24a. REC'D BY REGISTRAR</b> <b>Jan 17 '61</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>							



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

651

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00646

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Own Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Wade</b> Middle <b>Hampton</b> Last <b>Stull</b>				4. DATE OF DEATH Month <b>January</b> Day <b>26</b> Year <b>19 61</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 20, 1899</b>	
9. AGE (In years last birthday) yrs. <b>61</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Contractors</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John M. Stull</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Chipman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-18-0860</b>		17. INFORMANT <b>Mrs. Mary S. Stull</b>	
				Address <b>Thurmont, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Heart disease, Coronary occlusion</b> DUE TO <b>Coronary insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary insufficiency</b> (c) <b>Coronary insufficiency</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>11:55</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Thurmont, Maryland</b>	
20f. (City or town) <b>Thurmont, Maryland</b>				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 16, 1961</b> to <b>Jan. 27, 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>Jan. 25, 1961</b> , and that death occurred at <b>11:55 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>James K. Gray</b>				22b. DATE SIGNED <b>Jan 27 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>James K. Gray</b>				22d. ADDRESS <b>Thurmont, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-29-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>United Brethern Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond C. Crager</b>				ADDRESS <b>Thurmont, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 30 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00648

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Centerville Ijamsville 50 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Centerville, Ijamsville R.F.D.I</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural</b>		d. STREET ADDRESS <b>Rural</b>	
3. NAME OF DECEASED (Type or print) First <b>Melernica</b> Middle <b>Sarah</b> Last <b>Thompson</b>		4. DATE OF DEATH Month <b>January</b> Day <b>17</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 21, 1900-60</b>
9. AGE (In years) <b>61</b>		IF UNDER 1 YEAR: Months <b>17</b> Days <b>17</b> Hours <b>17</b> Min. <b>17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Keys</b>		14. MOTHER'S MAIDEN NAME <b>Lavina Putman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-10-8400</b>	
17. INFORMANT <b>James Thompson, Ijamsville R.F.D.I</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Artero sclerotic heart disease</b> DUE TO (c) <b>Artero sclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>January 17, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-21-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Eberneezzer</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick-Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. HICKS</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	
ADDRESS <b>111 Frederick, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 24 '61</b>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00649**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

(M)

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1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>York</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Unk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>York</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosemont Avenue</b>				d. STREET ADDRESS <b>6006 Market Street</b>			
3. NAME OF DECEASED (Type or print) First <b>EUGENE</b> Middle <b>HAROLD</b> Last <b>TOPPER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>23</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unk</b>	9. AGE (in years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Consulting Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fort Detrick</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lewis Topper</b>				14. MOTHER'S MAIDEN NAME <b>Unk</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-I 160-16-2546</b>		17. INFORMANT <b>Cassandra B. Topper (Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) (c) <b>gave rise to immediate cause (a), stating the underlying cause lost.</b> DUE TO							INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. O. Thomas, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				22b. DATE THEREOF <b>Jan. 24, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>York, Pennsylvania</b>	
22d. LOCATION (City, town, or county) (State) <b>York, Pennsylvania</b>				22e. REC'D BY REGISTRAR			
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison and Son, Frederick, Maryland</b>				24a. REGISTRAR'S SIGNATURE <b>Jan 25 '61</b>			



655

## CERTIFICATE OF DEATH

Reg. Dist. No.

00650

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg,</b>			c. LENGTH OF STAY IN 1b <b>Life</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>714 West Main Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Mary</b> Last <b>Wagerman</b>			4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1961</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1872</b>		9. AGE (In years last birthday) <b>88</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Joseph Knott</b>			14. MOTHER'S MAIDEN NAME <b>Anna Mary Butt</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Emmitsburg, Md.</b> <b>Mrs. Francis Sanders, 714 West Main Street,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral hemorrhage</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>10 years</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Emmitsburg</b>	(County) <b>Frederick Co.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Jan 1 35</b> to <b>Jan 19 61</b> , that I last saw the deceased alive on <b>Jan 19 61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>W R Cadle</b>		ADDRESS (Street, city or town, state) <b>Emmitsburg Md</b> DATE SIGNED <b>1-20-61</b>			
PHYSICIAN'S NAME (Type) <b>W R CADLE</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 23, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Emmitsburg, Frederick Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Wilson</b>		ADDRESS <b>Emmitsburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 23 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58





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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
656  
CERTIFICATE OF DEATH

00651

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>3 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>ELIZABETH</b> Last <b>WELLER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 24, 1883</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>			
13. FATHER'S NAME <b>Asha W. Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Mayhue</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Dr. Roy B. Weller—Same as item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> 434-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congestive Cardiac Failure</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b> <b>24 hrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 2, 1961</b> , to <b>Jan 4, 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan 3, 1961</b> , and that death occurred at <b>5A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>B. O. Thomas</b>				22b. DATE SIGNED <b>1/4/61</b>		22c. PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M.D.</b>	
22d. ADDRESS <b>Professional Building, Frederick, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 7, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Harris</b>	

MEDICAL CERTIFICATION

2

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH  
STATE OF MARYLAND

FILE

Registration

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

657

## CERTIFICATE OF DEATH

00652

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>24 hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>I.</b> Last <b>WHITMORE</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>9</b> Year <b>19 61</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 23, 1881</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>61</b>		IF UNDER 24 HRS. Months <b>7</b> Days <b>19</b> Hours <b>61</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Motorman &amp; sub-sta.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>op. = P.E. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Reuben Whitmore</b>				14. MOTHER'S MAIDEN NAME <b>Mary Newcomer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-10-9388</b>		17. INFORMANT <b>Mrs. Belva Whitmore</b> Address <b>Thurmont, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>ARTERIO-SCLEROTIC HEART DISEASE</b> DUE TO (c) <b>COMPLETE HEART BLOCK. BILATERAL PLEURAL EFFUSIONS</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 - weeks</b>  <b>YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/8</b> 19 <b>61</b> to <b>1/9</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>1/9/61</b> 19 <b>61</b> , and that death occurred at <b>1:30</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard C. Reynolds,</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Richard E. Reynolds</b>				22d. ADDRESS <b>9 E. Church St. Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-12-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>				ADDRESS <b>Thurmont, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 11 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

1

CHIEF

CERTIFICATE OF DEATH

1947

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00653

658

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>4 weeks</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lantz near Thurmont</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Mary</b> Last <b>Wilhide</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 19, 1879</b>
9. AGE (In years last birthday) yrs. <b>81</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Adelsberger</b>		14. MOTHER'S MAIDEN NAME <b>Ella Duphorne</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>George W. Wilhide</b>		Address <b>Lantz, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1) Fracture of left femur 2) Decubitus ulcers</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>10 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 28, 1960</b> , to <b>Jan 25, 1961</b> , that I last saw the deceased alive on <b>Jan 25, 1961</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Henry V. Chase</b>		ADDRESS (Street, city or town, state) <b>4 E. Church St</b>	
PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>		DATE SIGNED <b>1/25/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-28-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>
22d. LOCATION (City, town, or county) (State) <b>Thurmont, Md. Fred. Co.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Crager</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 30 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES M. JONES		DATE OF DEATH 1-1-1968	
AGE 35		SEX Male	
RACE White		EDUCATION High School	
BIRTH DATE 1-1-1933		BIRTH PLACE Baltimore, Md.	
MARRIAGE Married		SPOUSE'S NAME Mary Ann Jones	
OCCUPATION Salesman		PLACE OF DEATH Home	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
IMMEDIATE CAUSE Myocardial Infarction		INTERMEDIATE CAUSE Coronary Artery Disease	
FUNDAMENTAL CAUSE Atherosclerosis		PRE-EXISTING DISEASES Hypertension, Diabetes	
DATE OF AUTOPSY 1-2-1968		PLACE OF AUTOPSY Hospital	
SIGNATURE OF PHYSICIAN Dr. J. M. Smith		SIGNATURE OF REGISTRAR John Doe	
DATE OF SIGNATURE 1-2-1968		DATE OF SIGNATURE 1-2-1968	



**CERTIFICATE OF DEATH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

659

00654

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALFRED</b> Middle <b>GLAZE</b> Last <b>ZIMMERMAN</b>				4. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>30 Oct 1891</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner &amp; Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Florist Business</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Robert C. Zimmerman</b>				14. MOTHER'S MAIDEN NAME <b>Laura K. Fleming</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs. Helen G. Zimmerman (Same as item #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Prostate Gland with metastases to the Pelvis and the Retroperitoneal Lymph Nodes</b> DUE TO (b) <b>177X</b> DUE TO (c) <b>177X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Pyelonephritis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 1</b> 19 <b>60</b> to <b>Jan 2</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Jan 2</b> 19 <b>61</b> , and that death occurred at <b>8:35A</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>A. A. Pearre</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3 Jan 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. A. Pearre, M. D.</b>				22d. ADDRESS <b>4 E. Church St., Frederick, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-4-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 4 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4  
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

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PROTESTANT

MINISTER

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